SOUTHSIDE VIRGINIA TRAINING CENTER
Primary Inspection
August 19–20, 2004
OIG Report #102-04

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection of Southside Virginia Training Center during August 19-20, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. The quality statements were formulated with the input of a number of stakeholder groups. These groups included the five training center directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff, and directors of mental retardation services for community services boards. The quality statements address the facility's mission and values, access to services, service provision, facility operations and community relationships. The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into five primary sections focusing on each of the domains.

SOURCES OF INFORMATION: Interviews were conducted with twenty-nine members of the staff, including administrative, clinical and direct care staff. Tours were conducted in selected residential cottages and in on-site day treatment/training program buildings. The documentation reviews included, but were not limited to: five (5) clinical records, including approved behavioral plans; selected policies and procedures; staff training curriculums; and the facility quality management and strategic plans.

MISSION AND VALUES

1. The facility has a clear mission statement.

Interviews were conducted with twenty-nine staff members including administrative, clinical and direct care staff. All those interviewed had a working understanding of the facility's mission. Two members interviewed specifically referenced the use of person-centered planning as a key element in the facility's ability to meet its mission of providing quality individualized services. Other phrases used to describe the mission included: the provision of high quality services with the resources available, the protection of the residents, the provision of treatment designed for skills development and eventual community placement and the provision of campus-wide support services.

The facility's mission statement is that "SVTC is committed to excellence in providing quality, client-centered health and habilitative services for individuals with mental retardation. We provide a client-focused learning and living environment that positively affects the lives of the clients we serve. We extend our commitment beyond the facility to the wider community through service initiatives and partnerships of mutual interests addressing campus, local and regional opportunities and challenges. We provide

administrative and environmental support services to Central State Hospital, Hiram W. Davis Medical Center, and Virginia Center for Behavioral Rehabilitation." It was reported that the mission statement was last reviewed during a 2003 retreat, which included members of the Executive Steering Committee (ESC).

2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.

Respect, both for each other and the residents, was most frequently identified as a fundamental value that functions as the basis for all of the services provided by the facility. Other values shared during the interviews included: good communication, teamwork, client-focused services, striving to understand each other's job and a sound work ethic. The facility has a written values statement that includes but is not limited to the following values: the focus on the customer, showing respect, the importance of decision-making processes, responsibility at all levels of the organization, effective leadership, integrity and employee involvement as a means to quality improvement.

Seven of the persons interviewed cited the employee forum as an example of how the facility has operationalized these values. It was reported that this forum provides a respectful setting for staff to learn about and understand the role and function of other employees, communicate concerns and participate with management in the resolution of issues.

Staff on all levels from direct care staff to the facility director indicated the problem with "holdovers" as one of the significant issues facing this facility. This was one of the main issues discussed by the majority of staff during the previous inspection conducted by the OIG. The staff interviewed were noticeably less angry about this concern than during previous inspection interviews. The majority of staff maintained that decreased anger and frustration resulted from increased communication between staff and management. The interviews revealed that since the last inspection, management has provided a variety of avenues for staff to identify and address concerns. This has significantly decreased their sense that management does not have an understanding of or concern for their frustrations.

ACCESS / ADMISSIONS

1. Policies and Procedures that govern admission are consistent with the facility's mission statement.

The OIG reviewed policies governing admission for consistency with the facility's mission statement. The policy outlines admissions procedures that are based on individualized client needs. The facility review of an applicant focuses on ways in which the training center setting will support the person's stability and growth. Admissions policies are based on both the DMHMRSAS Departmental Instruction (101TX96) and the Admissions and Discharge Protocols established to guide both the facilities and the

community services boards (CSB). The policies and procedures are consistent with the facility's mission to provide client-centered health and habilitation services.

2. Admission to the facility is based on a thorough assessment of each applicant's needs and level of functioning.

Interviews with staff, a review of five resident records and a review of the facility policy that governs admissions demonstrated that the facility has an established mechanism for reviewing prospective admissions that is based on a thorough assessment of each applicant's needs and level of functioning in order to assure that institutional placement is appropriate.

Interviews indicated that it is the responsibility of the referring CSB to assure that the least restrictive alternatives to institutionalization are identified and considered prior to the application process. Once admission to the facility is sought, the Director of Community Services at the facility notifies the DMHMRSAS Office of Mental Retardation Services and convenes the Admission Advisory Committee. The committee reviews the application and assessments. The committee's decision is communicated to the Facility Director who has 30 days to notify the CSB of the decision. If it is determined that the client is not suitable for admission, the reasons for the denial of the admission are communicated in writing. If the consumer is accepted for admission, then the facility must seek judicial certification of eligibility. This process certifies that the person is eligible for admission, enabling the facility to accept the resident.

The community completes a number of assessments prior to admission, which are used as reference points for determining whether the applicant is appropriate for admission. Interviews indicated that the community assessments conducted and submitted as a part of the admission process include, but are not limited to:

- Current medical status including immunization history and psychiatric evaluation
- Psychological assessment (less than 3 yrs)
- Social history
- Individualized Educational Plan (IEP) for those 2 through 21
- Vocational evaluation (if in a community day program)
- Prescreening Report (including identification that no less restrictive alternative exists, training recommendations and discharge plans)

Eight (8) admissions were completed from July 2003 to July 2004. There was one person on the waiting list for admission to the facility as of July 1, 2004.

At the time of admission, the facility conducts its own assessments of the resident in order to develop the individualized habilitation plan. Assessments conducted include a nursing review at the time of admission and a complete medical examination (within 24 hours). Assessments by other disciplines include but are not limited to: psychology, occupational therapy, physical therapy, nutritional assessments, social services, and risk assessments such as falls.

3. The facility has a mechanism in place for addressing emergency admissions.

Interviews and a review of applicable policies and procedures demonstrate that the facility has a mechanism for addressing emergency admissions. Emergency care as defined by the facility policy is subject to the same review processes as regular admissions. Even though the facility uses much the same process as with regular admissions, the timeframe is much narrower due to the emergent nature of the applicant's condition. Interviews revealed that for the emergency admissions sought during the past year, most involved an unexpected or imminent change in the individual's living situation or environment, posing an increased risk of physical or emotional harm to the applicant.

It was learned that SVTC makes every effort to facilitate emergency admissions that are deemed appropriate as quickly as possible. Some of the factors those influences the speed in which the admission can occur include: the nature of the emergency, the gender of the client, and the availability of space. Clients with mental retardation who are experiencing acute symptoms of mental illness are more likely to be referred for emergency admission to Central State Hospital (CSH) where the services are considered by the training center staff to be a better fit.

During the last fiscal year, there were eight (8) requests for emergency admissions of which five (5) were admitted.

SERVICE PROVISION / CONSUMER ACTIVITIES

1. Activities are designed to facilitate socialization, skills acquisition and community integration.

Five resident records were reviewed during this inspection. All of the records outlined individualized goals consistent with the tasks identified in this quality statement. The prescribed objectives depended on the resident's degree of impairment and level of functioning. Individual strengths and preferences were utilized in the development of each resident's individualized habilitation plan (IHP).

The Office conducted a tour of and spent time observing habilitation services offered in Buildings 66 and 81. Interviews were conducted with eight staff members and one resident. The staff were knowledgeable of the goals and activities identified for each resident. Staff were observed treating the residents with dignity and respect as well as interacting with them in a loving and gentle manner. Staff spoke with pride of the accomplishments of the residents but also seemed to have realistic expectations regarding each person's ability. The activities observed were designed to strengthen fine motor skills, increase communication, support socialization skills and decrease the maladaptive behaviors that are identified as barriers to successful community living for the residents.

2. Residents are actively engaged.

Tours during this inspection occurred in both residential and training/active treatment areas during the evening and daytime shifts. During the evening tour, residents were having dinner or working on leisure/skills development activities. Residents were engaged in small group activities such as story telling and crafts. Observations also occurred during the morning activities, which included attending to the activities of daily living, having breakfast and generally preparing for the day. All of the residents in the areas toured during the morning were scheduled to go to either day treatment activities in the habilitation programs or pre-vocational services. Staff were supportive and assisted residents in accomplishing their tasks. The interactions observed were designed as learning opportunities and not simply staff doing the tasks for the residents.

3. Activities occur as scheduled.

Day treatment programming was noted to occur as outlined on the residents' schedules. Staff indicated that the majority of activities occur as scheduled except when staff shortages result in a delay. Staff indicated that delayed activities were completed as soon as staffing patterns allowed.

4. Residents are supported in participating in off-grounds activities.

Interviews with staff revealed that the residents have opportunities to participate in individual and small group activities in the community, such as going shopping, to the park, for rides, out for dinner and to Kings Dominion. Evidence of community integration activities was also noted in all of the resident records reviewed.

5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.

Interviews indicated that the facility plays an active role in discharge planning for the resident. Residents are encouraged to visit community placement options, including extended visits designed to determine how well the resident will function in a new setting. Facility staff work with community staff in aiding the resident's acclimation to the new environment but these services are very limited due to resource constraints. Staff offer consultation services for residents who have been recently discharged as well as community residents that are at risk of losing their placements in a effort to help the person(s) remain in the least restrictive setting possible.

FACILITY OPERATIONS / SAFE ENVIRONMENT

1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.

SVTC has multiple ways of assessing and monitoring the safety and security of the residential units. The facility is unique across the state facility system in that it is the only facility that has its own police force and fire department. The officers and firemen are responsible for the entire campus security, which includes Southside Virginia Training Center, Central State Hospital, Hiram W. Davis Medical Center and the Virginia Center for Behavioral Rehabilitation. The police conduct perimeter checks including routine rounds of the grounds and buildings. Security and fire safety personnel monitor the campus and conduct regular safety inspections.

The facility has an Environmental Safety Committee that reviews and monitors a number of environmental factors. The facility's Buildings and Grounds Department has a system for addressing work orders. This system prioritizes requests based on the level of risk involved. Life, health and safety concerns are addressed immediately. Routine work orders are targeted for completion in seven working days or less.

The facility has a risk manager who reviews and tracks critical incidents and other areas of concern. Data is collected that enables the risk manager to conduct analysis of a variety of factors. The risk manager shares this information with the Executive Steering Committee during morning reports. The morning reporting process outlines significant events for the previous 24 hours. Members of the management team are present at the meeting and address issues as identified.

2. There are adequate safeguards to protect residents from abuse and neglect.

Interviews indicated that the facility adheres to Departmental Instruction 201(RTS) 03 (Reporting and Investigating Abuse and Neglect of Clients), which governs the procedures for reporting and investigating allegations of abuse and neglect. The facility's abuse and neglect investigator is a member of the police force and is specifically trained.

Allegations are reported to the facility director who forwards the allegations to the investigator for review and follow-up as appropriate. The human rights advocate reviews all allegations of abuse and neglect and monitors the investigation process on behalf of the consumer.

Relevant staff training focuses on issues associated with abuse and neglect and client-centered approaches to care. Staff throughout the facility were observed treating the residents with dignity and respect.

The facility director is featured in a video that provides a clear message regarding management's stand on not tolerating abuse and neglect within the facility. It also is a tool for reinforcing the values of dignity and respect.

During the first six months of 2004, there were 45 allegations of abuse and neglect, of which 21 were substantiated.

3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.

The risk manager tracks critical incidents. This includes those incidents that fit the criteria for reporting to VOPA and those that impact patient safety but do not result in injuries such as sometimes occurs with resident falls and incidents of peer-to-peer aggression. Data is collected and routinely communicated to management and staff. Performance improvement teams have been designed to address issues identified through this process.

Nursing maintains data on critical indicators such as the number of pressure ulcers, the number of residents that require special hospitalization, the number of persons that have been diagnosed with dehydration, and the number of medication errors. The information is used to identify possible areas in which additional training or supervision may be needed. The facility conducts routine safety checks of the physical plant and prioritizes issues that have life, health and safety implications. These are addressed immediately.

Data provided by the facility indicated that there were 27 critical incidents reported to VOPA and the OIG from January to June 2004. There were 89 incidents of peer-to-peer aggression during the same reporting period, of which 60 were noted as resulting in injuries to one or both of the residents involved.

4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.

Interviews revealed that SVTC rarely uses locked or isolated time-out with its residents. Isolated timeout is defined as "the removal of a client from ongoing reinforcement to a specifically designated time-out room." SVTC complies with CMS regulations, which outline the circumstances under which ICF/MR facilities can use the time-out room. These include:

- The use of the time-out room has to be a part of an approved systemic time-out program.
- The use of the time-out room can not be used as an emergency intervention,
- The client is under direct constant visual supervision while in the time-out room
- The door to the time out room is held shut by staff or by a mechanism requiring pressure from staff

Exclusionary time-out is utilized only when the resident's behavior is identified as maladaptive and occurs only as outlined in the resident's behavioral plan. The Local Human Rights Committee reviews all behavioral plans that call for the use of restrictive procedures. Information provided by the facility reported there have been four incidents of isolated time-out at the facility since January 2004. There were also four incidents in

which emergency mechanical restraints were used. Interviews indicated that during the second quarter of 2004, there were 197 residents with approved behavioral plans, four of which had restraint or isolated time out as a part of the plan. There were also 360 residents with protective restraints, 53 of which required the use of a wheelchair during transport.

5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.

Human Rights training is provided for all staff at the time of their orientation and annually thereafter. Residents and their legally authorized representatives are advised of the rights and the complaint process at the time of admission and at least annually. Documentation of this notification was in the resident records reviewed.

The facility has both an informal and formal process for handling complaints. The facility director handles informal complaints. The team was able to actually observe the informal complaint process. Complaints that are brought directly to the advocate's attention or informal concerns that cannot be resolved at the facility director level become formal complaints and are handled as outlined by the Human Rights regulations. The facility director notifies the advocate of the informal complaints and how they are resolved. Interviews revealed that these were addressed in a timely manner. During the first six months of 2004, there were 9 informal and 3 formal complaints handled within the facility.

6. Medication usage is appropriately managed.

The facility has established policies and procedures for the handling of medications. Medication errors are tracked through the development of performance improvement indicators designed to promote the reduction of errors. The 2004 Nursing Annual Report indicated that the average number of medication errors reported for this year was .015 errors per client per month. The report indicated that with over 3000 medications (not doses) given every day, it was decided that a performance improvement process would be initiated to assure that accurate reporting of errors is occurring. The performance improvement initiative has been designed to capture enough data regarding medication administration to increase confidence in the errors rate. Increased education and training regarding what constitutes an error and when to report will be components of the initiative. Also supervisors will be conducting periodic and random reviews of medications practices and/or cart counts. Interviews with staff described adequate safeguards in both the management and administration of medications.

The first safeguard in assuring that medication is managed appropriately within the facility is training. The facility uses a curriculum approved by the Board of Nursing. Staff must pass written tests and demonstrate competency in a number of areas regarding the use of medications. Ongoing supervision regarding competency is a component of staff performance evaluations.

7. There are mechanisms to address areas of concern regarding staff safety.

There is an expectation at the facility that staff injuries are to be reported in a timely manner even though it was acknowledged by nursing and mid-management that this varies in practice across the facility. The Human Resources Department tracks the injuries, as well as monitors those that result in claims, absences and disability.

The Safety Committee addresses issues identified as staff safety risks. Environmental safety checks identify and correct physical conditions that could have an impact on the safety of both the staff and the residents. Staff may notify their supervisors, the risk manager or facility safety officer regarding identified areas of risk within the facility.

FACILITY OPERATIONS / LIVING ENVIRONMENT

1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.

Efforts at personalizing the residents' rooms were evident. Staff described additional projects currently underway for obtaining additional items that were requested by the residents.

Blinds for privacy are used in resident's bedrooms and the common areas. Other materials are used for the same purpose when behavioral and/or safety concerns are identified.

2. The residential environment is clean, odor free and well maintained.

Tours of Cottages 16, 17, 26 and 27 revealed that the residential areas were clean and well maintained. The furniture was appropriate for the number of residents and population served. Bathrooms were clean and odor free.

A small electrical gadget of undetermined purpose was noted on the wall in a resident's bedroom in Cottage 26. Staff indicated they would submit a work order to have the object either repaired or removed. In checking the following day, it was determined that this had been addressed.

The facility identified that following as the three most critical capital improvement projects:

- Renovations to the cook-chill system (estimated cost $2.2 million)
- Phase three of the work on the steam distribution systems (estimated cost $1.5 million)
- Sanitary and sewer system improvements (the estimate is unknown as the work needed is in the process of being evaluated)

The facility is currently addressing the following projects:

- Project number 720-16373-01 on the steam tunnels which is 99% completed
- Project number 720-16373-02 regarding a boiler replacement, which is scheduled for completion in July 2005
- Project number 720-16156-01 on HWDMC fire alarm system that is 98% completed.

3. There is evidence that the residents are being taken care of by the facility.

Throughout the tours, the team had an opportunity to observe the residents. All were properly clothed, clean and appeared well provided for by the facility. Observations of the interactions between the staff and the residents revealed that the staff treated the residents with dignity and respect. Staff related to the residents in a caring yet professional manner.

4. The facility provides for access to primary health care that is coordinated and comprehensive.

On the day of the inspection, there were 384 residents. The facility has four (4) primary care physicians and the facility medical director. The caseload for each physician is approximately 1 to 95. The medical director maintains a caseload of approximately 20 persons. In addition, residents have access to a number of clinic services through Hiram W. Davis Medical Center or the Medical College of Virginia. The facility uses either Southside Regional Medical Center or the Medical College of Virginia for special hospitalization and emergency services. The facility has part-time psychiatric coverage, which provides services for those individuals at the facility who are dually diagnosed.

SVTC has a clinic, which maintains 24 hour nursing coverage. All residents identified as needing care are seen in the clinic except for emergencies. In the event of an emergency, the RN is the first responder contacted but staff are trained to make basic assessments and contact the local rescue squad as appropriate, prior to the arrival of the RN on the unit. Each unit has nursing coverage during the day and evenings, but the clinic nurse provides coverage during the night shift for the two units that do not have a nurse assigned to the unit during that shift.

There is no physician on-site during the evening or night shifts, but an on-call system is utilized for providing coverage. Nursing staff reported an excellent response time by the on-call physicians, usually less than five minutes.

5. The facility has a mechanism for accountability of resident's money.

There is a patient accounts division under the facility's Office of Fiscal Management that maintains records of the patient's money. Each person's qualified mental retardation professional (QMRP) is responsible for tracking the management of the resident's funds. Receipts are required in order to maintain accountability for items purchased either by the residents or on behalf of the residents.

FACILITY OPERATIONS / STAFFING PATTERNS

1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.

Of the 15 staff members interviewed, all maintained that the facility was able through mechanisms such as "holdovers" and overtime maintain a sufficient qualified workforce to address the supervision and training needs of the residents.

During the tours, it was noted that in Cottage 26 and Cottage 27, there were 12 residents (six per side) and 5 staff members present. During the tours of Cottages 16 and 17, there were 16 residents (eight per side) and 6 staff present. Two of the staff present were programming staff that assist in the cottages during morning preparation activities then travel with consumers to the day programming activities. Three staff members indicated they were doing overtime from the previous shift.

The facility has been working to enhance its recruitment efforts. It was reported that on one day during the past six months, the facility was successful in having all of its direct service associate (DSA) positions filled, which was viewed by management as a huge accomplishment. Data maintained for 2004 revealed a significant decrease in the number of DSA position vacancies. The retention of staff is the next challenge identified by management for the facility. As recruitment efforts have improved and been sustained, the retention of staff has remained relatively the same. The facility has been increasingly successful in hiring and maintaining professional staff.

One supervisor, who is anticipating the loss of five seasoned employees (25 +years of service) due to scheduled retirement during the first quarter of 2005, expressed concern regarding the imbalance of new and seasoned employees that this will create in that unit. He related that new staff benefit tremendously by being mentored both formally and informally by seasoned and dedicated personnel. The supervisor indicated that it is primarily through time and contact that staff are able to recognize the resident's needs, preferences and communication styles.

2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.

Management and direct care staff indicated that "holdovers" continued to be a major problem at the facility and one of the primary sources of staff frustration. During the inspection, there were ten holdovers in one building alone due to call-ins and the on-site working visit by a guardian ad litem, which required the availability of staff to assist in the transport of residents for meetings. Even though the event with the guardian is rare, the combination of call-ins, vacations, increased number of residents on 1:1 and staff out sick or on short term disability has keep the need for holdovers high. Management says that they are able to maintain a safe environment with adequate support, however, they are limited in the number of activities they are able to provide the residents because of the holdover issue.

Staff expressed concern about the excessive delay between the time they work the overtime and when they are paid. Several related that this is often a six to eight week delay. Two employees said that the delay in compensation made it very difficult to track for accuracy. One staff member interviewed indicated that it took considerable effort to demonstrate she had not been accurately compensated for the overtime work performed.

3. Direct care staff possesses the competencies necessary for providing services.

Interviews with training and supervisory staff, as well as a review of the training materials revealed that the majority of critical tasks associated with staff duties required competency reviews, which involved either tests or demonstrations.

FACILITY OPERATIONS / SYSTEM PERFORMANCE

1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.

Interviews revealed that the facility views the expertise housed in its information technology department as essential to its ability to streamline care in order to provide more effective and efficient services to the consumers. One example provided was the development of an automated record keeping system for writing and maintaining individualized habilitation plans (IHP). This system gives qualified mental retardation professionals the ability to create consumer plans of care online using a menu of options. The design supports the development of individualized plans but allows for required categories to be completed with greater accuracy and ease. Staff are in the process of being trained on how to use the system. All those interviewed indicated that this system should dramatically reduce the time spent in completing paperwork, which was identified as an issue by staff.

Data collection is used in a wide variety of ways to track trends in key areas by the facility. Some of the indicators tracked through data collection include the percentage of IHPs developed on time; the number of residents without legally authorized representatives; the number, type, location and time of critical incidents; incidents of peer to peer aggression; medication errors; and medication usage.

2. There is a system for continuous quality improvement (QI).

SVTC has a well-defined and managed quality assurance process. The QA strategic plan has four goals and annually defined strategies for meeting the goals established. A quality subcommittee has been established to monitor the completion and outcomes of strategies in each of the four goal areas. These committees report to the Executive Steering Committee. Data is collected and analyzed by each subcommittee to determine if there is evidence that improvement towards the identified goals is occurring.

3. Consumers and other stakeholders have an active role in program development and quality improvement activities.

Families are not a formalized part of the quality assurance process within the facility. The facility does have a very active parents organization, Parents of SVTC, which meets regularly with members of the facility management staff. Members of this organization are asked to provide feedback to the facility.

COMMUNITY RELATIONSHIPS

1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in their catchment area.

Most of the work that surrounds maintaining community relationships occurs as a result of providing services to the residents through the admissions, discharge and outreach processes. The frequency of interactions is expected to increase dramatically with the anticipated discharges through the 60 waiver slots recently allotted to the facility. The Director of Community Services indicated that there is already some pressure being exerted by the community for the facility to move more rapidly than it is prepared to move on facilitating the discharges. It is the facility's plan to discharge those identified over the next two years or sooner as the community services boards become ready to receive them. One community services board was reported as having identified placements and has asked to begin the discharge of six of their residents. The strategies for successfully completing this task had not been addressed between the community and the facility at the time of the inspection.

SVTC maintains a very active relationship with the CSBs in Region IV. The facility director meets regularly with the CSB executive directors and other staff work actively with the CSB mental retardation director. Over the past several years, SVTC has been a key player working with the CSBs through the reinvestment/restructuring initiative to modify services within the facility to meet community needs. Several new programs have been created.

2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:

a. With Community Services Boards

Even though there has not been a formalized survey conducted with the community services boards, there are a number of informal mechanisms for identifying the community's satisfaction with the services provided.

b. With parents and/or legally authorized representative

The facility has conducted satisfaction surveys with the families of residents. The survey was not conducted last year because it was reported that the Central Office completed a survey for the facilities. Facility staff indicated that they did not receive any feedback regarding the outcome of the survey.

c. With the DMHMRSAS Central Office

The facility indicated that it sends its annual plan to the Central Office yearly but to-date has never received any feedback regarding the document or the outlined plan of action.

It was indicated that the risk manager at the facility has the most contact with staff at the Central Office through ongoing meetings and reviews of the work associated with the overall risk management process.

The facility director has regular contact with Assistant Commissioner for Facility Operations and other facility directors during informal and formal meetings but the discussions rarely focus on the satisfaction of the Central Office with the work completed by the facility nor do the meetings provide an opportunity for facilities to provide feedback to the Central Office about the effectiveness of the relationship. Of those specifically asked to address this statement, all indicated that more information would be helpful and welcomed.

3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.

Management at the facility had a good working understanding of the community's capacity to effectively address the needs of this challenging population. However, staffs' understanding of the current capacity of the community is not reflective of the more complicated clients that are being served at that level.

Nursing and medical staff identified a lack of trained and interested professionals in the community to provide the time-intensive specialized services needed by the residents as a major difference between the community and the facility in addressing the healthcare concerns of this special population. One example provided was routine dental cleaning, which usually requires anesthesia, proper positioning and more involved follow-up care. Current funding arrangements makes it difficult for the facility to provide this care for consumers who live in the community.

Direct care staff indicated that the community providers are unprepared to receive their residents and do not provide the staffing patterns necessary to maintain the skills residents have acquired in the facility. Eight of the ten interviewed indicated that the community chose to use medications instead of behavioral plans to address problems in the community, which the facility staff viewed as a failure for the resident. The majority of direct care staff interviewed did not have confidence in the community's ability to provide adequate care of the residents upon discharge. However, this perception is based primarily on their experience with the relatively few residents that have returned to the facility post discharge. The recidivism rate at this facility is low.

Interviews with staff revealed that they did not appear to have a common understanding of the facility's role within the community. Management described the facility's role as

to provide a safety net for the community when the necessary resources for providing the services needed by the consumer cannot be provided in a less restrictive setting. Staff, however, indicated that it is the responsibility of the facility to provide services for any consumer with mental retardation that chooses institutional care.

4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.

The facility is not licensed to provide services for children (CORE license) so it cannot provide respite services for this population. All other age groups, including geriatric, are provided respite services. The facility had 6 requests for respite care last fiscal year and were able to provide services for all of them.